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Leadership and party politics

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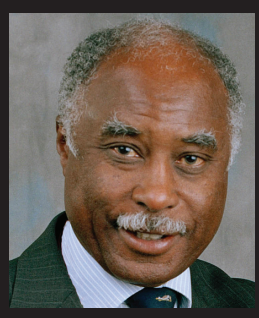

BERNARD RIBEIRO
PRESIDENT

It is rare to attend a national meeting when a speaker holds the audience spellbound from beginning to end. Leadership is a topic that is often discussed these days, but few of us really know what it means, perhaps because we have few medical examples. Invariably those who are able to speak from experience are leaders of teams, be they in sport or business. My first experience of being spellbound by a speaker was at the annual meeting of the Royal Australasian College of Surgeons in 2000 when the late Sir Peter Blake, whose successful defence of the America's Cup in 2000 was the first by any non-American team, gave a lecture on leadership and motivation. It was clear that he led by example and it was easy to see why.

In September 2007 I attended the annual meeting of the Royal College of Physicians and Surgeons of Canada in Winnipeg. The keynote speaker was Dr Joe MacInnis who spoke without notes but used a few graphic video clips of deep-sea submarines exploring the ocean floor and the hazards of such an operation, only made possible through close and trusting teamwork. He showed a rare interview of Buzz Aldrin describing the first moon landing when he and Neil Armstrong were the first humans to land on the moon on 20 July 1969. The interview was interspersed with playful images of their moonwalk. Little did we realise that they had landed the capsule with less than 20 seconds of fuel remaining, after struggling to find a clear landing zone.

Dr Joe MacInnis described three qualities of leadership:

1. resolute courage
2. fierce innovation, and
3. creative collaboration.

One can still see evidence of 'resolute courage' in Buzz Aldrin's steely eyes, 38 years after the event. With such leadership goes untold bravery – how can we mere mortals hope to emulate the actions of such brave men? Their answer would be to stand up and be counted for our beliefs.

In the *Bulletin* last June[1] I made an unpopular statement about the new immigration rules introduced on 7 March 2006. This was intended to restrict access to training for overseas doctors by withdrawing permit-free training. I noted that with the expansion of our medical schools and the migration of EU doctors to the UK, the prospect of medical unemployment was real and would occur unless something was done to limit the numbers of overseas doctors entering the UK for training and employment.

As the prospect of medical unemployment looms large, we must either find more training numbers by restricting access into the first year of specialty training (ST1) and freeing up numbers to boost selection into the third year (ST3), or accept restrictions on overseas trainees. The former is proving difficult to achieve. It may not be politically correct to say so, but prior to MMC a distinction was made between training posts reserved for doctors with a right of abode in the UK and posts for overseas doctors without this right. Changes in HR practice, which demand equity of access, makes the UK one of the few countries in the world where nationals are not given priority over others.

Leadership not only requires the demonstration of bravery but the need for resolute courage in the face of difficult decisions. That is why my views on medical immigration and the brain drain that it creates have not changed. '*I believe that as a profession we should take responsibility for the consequences of this brain drain and work to reverse it…Unpopular though it may be, the new regulation marks a start in reversing the brain drain.*'[1] One year on I still believe this holds true.

Sir John Tooke's interim report

The Medical Training Application Service has been the source of much distress for trainee surgeons and a huge lobbying issue for this College throughout 2007. The publication on 8 October 2007 of Sir John Tooke's interim report reviewing Modernising Medical Careers (MMC) hopefully heralds a sea change at the Department of Health, with the recognition of the need for broad-based early training with greater flexibility and more rigorous selection for craft specialties. His report takes account of the concerns of this College and in particular recommends that a further point of selection is required between core and specialty training. He acknowledges that MMC requires trainees to make specialty choices too early in their careers.

Tooke's initiative to split the foundation years (F1 and F2), returning the first half back to pre-registration, is common sense. This will ensure that the first year of pre-registration training remains under the supervision of the medical schools and the General Medical Council (GMC), thus guaranteeing UK medical students their first job. I am confident that the foundation principles enshrined in F2 can be amalgamated into the core specialty stems, while allowing trainees to acquire some of the specialty skills and experience they require to progress.

His recommendation to follow this with a new period of core specialty training – time-limited to three years – will allow trainees to progress according to their ability, knowing they will face a further period of selection in their chosen specialty. This will provide ample opportunity for trainees to undergo the 'taster' placements that were originally envisaged in MMC, but which proved impossible after the rules were changed to dictate run-through training within (and not across) specialties. The return of flexibility was a plea of nearly every respondent to the Tooke questionnaire and something that I firmly recommended.

The creation of core specialty training will ensure that if a trainee fails to be selected into specialty run-through training they will be better equipped to work in the staff and associate specialty grades. Tooke also proposes a fundamental overhaul of the role and title of the non-consultant career grades, and a review of the end point of training to the certificate of completion of training (CCT) to make sure that we continue to produce consultant surgeons able to function as independent specialists.

For those who are concerned that uncoupling core training from specialty training will be a return to the old days I would urge them to read *Unfinished Business* very carefully, where the chief medical officer (CMO)'s original intention was not to do away with the SHO grade but to limit it to two years after the foundation programme.[2]

The position of the Postgraduate Medical Education and Training Board is also questioned, as if it came into existence along with the now discredited MMC process. The recommendation is that it comes under the auspices of the GMC, reporting to Parliament and not to the DH. At a stroke Sir John's recommendations, if implemented by the government, will conclude the nightmare of the last three years and allow a proper career structure in accordance with the wishes of the College and the profession as a whole, not least in the interests of our patients.

Party politics

This year for the first time the College was represented at all three political party conferences through a collaboration known as the Health Hotel, 36 health organisations that come together to hold joint fringe events at political party conferences. Member organisations include the GMC, the British Medical Association, the Healthcare Commission, The Health Foundation, the NHS Confederation and the King's Fund, to name a few.

The College partnered with The Health Foundation and the Alzheimer's Society to hold a debate on the reconfiguration of NHS services, entitled *Going the distance: How far is too far to travel for health care?* The panel comprised a member of Council, a patient

representative and a party spokesman. I was on the panel for the debate at the Labour Party conference in Bournemouth (see photograph), Tony Mundy attended the Liberal Democrats' conference in Brighton and Dermot O'Riordan was at the Conservative Party conference in Blackpool. We used the debates to highlight the College's views that for some people, the risk involved in travelling that extra distance is worthwhile in terms of the quality of care received; and we agreed with the sentiment that the treatment should be 'local where safe, central where necessary'.

As well as holding my own debate, I had the opportunity to meet informally the Labour health team, their officials, and senior representatives of the major health care organisations, to outline our policies and exchange views. It is vital that the College is seen to take a leadership position on the key debates in health care and I believe our profile and our scope to influence policy can only be enhanced by this initiative. This fulfils my ambition for the College that it should engage more effectively with politicians. It is clear that our involvement was warmly welcomed by all political parties.

May I take this early opportunity to wish all of you a very Happy Christmas and New Year.

References

1. Ribeiro BF. A varied month. *Ann R Coll Surg Engl (Suppl)* 2006; **88:** 186–87.
2. Department of Health. *Unfinished Business: Proposals for reform of the Senior House Officer grade.* London: DH; August 2002.

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